For Training Purposes Only

ACCESS GUIDELINES TO STATE SERVICES FOR PERSONS WITH TRAUMATIC BRAIN INJURY

Version 2

THESE GUIDELINES WERE PRINTED IN APRIL 2003. AGENCY POLICIES AND PROCEDURES MAY HAVE CHANGED SINCE THE DATE OF PUBLICATION.

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SECTION I.

INTRODUCTION

Purpose of this Document

Approximately 1.9 million Americans are involved in motor vehicle collisions, falls, recreation activities, and violence related events that result in a traumatic brain injury (TBI) each year. Nationwide, more than 50,000 people die annually due to TBI and 5.3 million U. S. citizens, or two percent of the population, live with a disability resulting from TBI.[1] TBI is the leading cause of death and disability in persons under the age of 18 and males are twice as likely as females to acquire a TBI.[2]

In June of 1999, the need to develop a plan regarding TBI was identified as a result of a state department assessment on TBI in Michigan, and the following challenge was set:

> "Develop a community-based, coordinated system to provide an array of services... to all persons with TBI. Because individuals with TBI can have such different types of needs and levels of impairment, planning for a system of care should address the use of supports coordination to link people with appropriate services to address individual needs and to assist with "navigating the system.""[3]

The goal of the *Access Guidelines to State Services for Persons with Traumatic Brain Injury* (*Access Guidelines*) is to help providers to know when and how to direct persons with TBI to other agencies and to ensure access and coordination of services. The *Access Guidelines* are the first step in the process of recommending a system of service coordination between the state agencies listed below.

How to Use these Access Guidelines

The *Access Guidelines* describe services relevant to persons with TBI from four main public agencies:

- Community Mental Health and Substance Abuse Services Programs (CMHSP)
- Family Independence Agency (FIA)
- Michigan Department of Community Health – Long Term Care (LTC)
- Michigan Department of Education – Office of Special Education and Early Intervention Services

The *Access Guidelines* are designed to be used in conjunction with the *Michigan Resource Guide for Persons with Traumatic Brain Injury and their Families* (MRG), which is a comprehensive guide for finding services in the state of Michigan. The MRG includes information on services offered by all levels of government as well as non-profit organizations. Please refer to the MRG for additional descriptions of the services listed in these *Access Guidelines* and for information on many other services offered throughout the state. (See page 2 for information on how to obtain copies of the MRG.)

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[1] U.S. Department of Health and Human Services. (1999). Traumatic Brain Injury in the United States: A Report to Congress.

[2] National Institutes of Health. (1998, Oct). Rehabilitation of Persons with Traumatic Brain Injury, Report of the Consensus Panel, 27.

[3] Michigan Traumatic Brain Injury - Results of the State Department Assessment. June 1999.

Services for children are included in these *Access Guidelines*, but many other services for children are available, including Children's Special Health Care Services and the Children's Waiver Program. For information on additional services available for children and adults, please refer to the MRG.

The contents of the guide are broken down for each agency into the following sections:

- Overview of Services: a table that provides a simple overview of services offered.
- Description of Services: information about services provided.
- Contacting the Office or Service Provider: includes information on how to get in touch with an agency, how to address special communication needs and information on transportation services.
- Determination of Needs and Eligibility: explains the process of determining eligibility for services and identifying individual needs.
- Decision Tree: a figure that graphically depicts the beginning of the eligibility determination process.
- How to Appeal a Determination: provides information on how to begin the appeal process if there is disagreement on determination of eligibility or services provided.

Each of the agencies discussed in these *Access Guidelines* will share information regarding a consumer with other agencies or organizations if the consumer or the consumer's guardian has signed a release form.

The *Michigan Resource Guide for Persons with Traumatic Brain Injury and their Families* (MRG) may be downloaded free of charge in English, Spanish or Arabic from the following website: www.michigan.gov (search for "traumatic brain injury").

To order copies of the MRG, contact:

Brain Injury Association of Michigan
8619 West Grand River Road, Suite I
Brighton, MI 48116
Phone: (800) 772-4323
Fax: (810) 229-8947
Or,
Michigan Public Health Institute
2440 Woodlake Circle, Suite 190
Okemos, MI 48864
Phone: (517) 324-8398
Fax: (517) 324-6099

SECTION II.

COMMUNITY MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES PROGRAMS

Community Mental Health Services Programs (CMHSP)

Table 1: Overview of Community Mental Health Services for Children and Adults

Community Mental Health Services	Direct Services Provided	Public Funding for Services[1]	Information & Referral Provided	Eligibility	Contact
Case Management	Yes	Yes	Yes	Severity and Income/Asset Criteria	Local CMHSP
Individual/Family/ Group Therapy	Yes	Yes	Yes	Severity and Income/Asset Criteria	Local CMHSP
Medication Admini-stration and Review	Yes	Yes	Yes	Severity and Income/Asset Criteria	Local CMHSP
Crisis Intervention Services	Yes	Yes	Yes	Severity and Income/Asset Criteria	Local CMHSP
Applied Behavioral Services	Yes	Yes	Yes	Severity and Income/Asset Criteria	Local CMHSP
Mental Health Emergency Services	Yes	Yes	Yes	Severity and Income/Asset Criteria	Local CMHSP
Inpatient Psychiatric Services	Yes	Yes	Yes	Severity and Income/Asset Criteria	Local CMHSP
Assertive Community Treatment (ACT)	Yes	Yes	Yes	Severity and Income/Asset Criteria	Local CMHSP
Assessments	Yes	Yes	Yes	Severity and Income/Asset Criteria	Local CMHSP
Crisis Residential Services	Yes	Yes	Yes	Severity and Income/Asset Criteria	Local CMHSP
Enhanced Health Services	Yes	Yes	Yes	Severity and Income/Asset Criteria	Local CMHSP
Mental Health Home-Based Services	Yes	Yes	Yes	Severity and Income/Asset Criteria	Local CMHSP
OT, PT, Speech Evaluation	Yes	Yes	Yes	Severity and Income/Asset Criteria	Local CMHSP
Treatment Planning	Yes	Yes	Yes	Severity and Income/Asset Criteria	Local CMHSP
Transportation to Day Program	Yes	Yes	Yes	Severity and Income/Asset Criteria	Local CMHSP

[1] Funding for services may be limited due to budget constraints.

Description of Community Mental Health Services

Community Mental Health Services Programs (CMHSPs) are contracted by the State of Michigan Department of Community Health to provide a full array of community-based support services for eligible individuals and their families. While some CMHSPs may directly operate treatment programs, most CMHSPs establish a network of agencies and professionals to provide treatment services. There are a number of covered services that the CMHSPs are required to provide, including the following:

Case Management Case management services assist mental health clients in gaining access to needed medical, social, educational, financial and other services. Core elements of case management include assessment, development of an individual plan of service, linking or coordination of services, re-assessment/follow up and monitoring of services.

Individual/Family/Group Therapy Therapy is a treatment activity designed to reduce maladaptive behaviors, restore normalized psychological functioning and improve emotional adjustment and functioning.

Medication Administration and Review Medication administration and review services are provided by a psychiatrist for the purposes of evaluating and monitoring medications and their effects.

Crisis Intervention Services Crisis intervention services consist of face-to-face or phone contact with an individual for the purpose of resolving a crisis or emergency situation requiring immediate attention.

Applied Behavioral Services Behavioral services are actively designed to reduce maladaptive behaviors, to maximize behavioral self control or to restore normalized psychological functioning, reality orientation and emotional adjustment, thus enabling the individual to function more appropriately in interpersonal and social relationships.

Mental Health Emergency Services Emergency services offer twenty-four hour crisis intervention to persons experiencing a psychiatric crisis. In an emergency, consumers can call the mental health 24-hour crisis line listed in the phone book under “Mental Health”. Individuals with an emergency may walk into any mental health location or hospital emergency room for immediate treatment. Services available include assessment and referral, and screening for psychiatric hospitalization of Medicaid and uninsured consumers.

Inpatient Psychiatric Services Inpatient psychiatric services are provided around the clock in a hospital setting.

Assertive Community Treatment (ACT) ACT is a comprehensive and integrated set of medical and psychosocial services provided on a one to one basis primarily in the client's residence or other community locations by a mobile multidisciplinary mental health treatment team.

Assessments (health, psychiatric, psychological testing) Assessments are comprehensive evaluations of the physical, cognitive, behavioral or emotional needs/status of a client that may result in the initiation of a specific CMHSP service, additional assessment/consultation or referral to an appropriate community resource.

Crisis Residential Services (short-term alternative to in-patient psychiatric services) Intensive residential services provide a short-term alternative to inpatient psychiatric services for persons experiencing a psychiatric crisis.

Enhanced Health Services Health related services that are beyond the responsibility of the consumer's health plan are provided for rehabilitative purposes to improve overall health and ability to care for health related needs.

Mental Health Home-Based Services Family focused intensive services are provided to individuals and families with multiple service needs who require access to an array of mental health services.

Occupational Therapy (OT), Physical Therapy (PT), Speech Evaluation OT, PT and speech services are provided by a licensed professional or assistant to assist with achieving optimum functioning.

Treatment Planning Activities associated with the development and periodic review of an individual plan of service are organized, including all aspects of person centered planning as well as pre-meeting activities.

Transportation to Day Program Transportation is provided to and from the consumer's residence, so a consumer may participate in a covered day program or psychosocial rehabilitative program.

Contacting the Office

Contact information for local CMHSPs can be found in the phone book under "Mental Health" or "County Government" in the yellow pages, or by calling Information. The Michigan Association of Community Mental Health Boards (MACMHB) also provides local CMHSP information at (517) 374-6848. If it is not an emergency, an initial screening over the phone or in person will be done to determine eligibility and, if eligible, an appointment/treatment will be arranged.

A TTY should be requested for persons with a hearing impairment. Translation will be available for those with limited English proficiency. These services must be made available to the consumer within 24 hours of contact.

Transportation services are specific to individual treatment agencies. The treatment agency may be able to coordinate transportation with local transportation providers. FIA is a provider for transportation to medically required appointments for persons who are Medicaid eligible.

Determination of Needs and Eligibility

There are three ways persons with TBI may qualify for CMHSP services: being classified as having a developmental disability, mental illness or substance abuse problem. Eligibility determination may begin with a brief phone screening, followed by a face-to-face psychosocial assessment. Documentation and information on the presenting problem, history of problems, prior treatment and current symptoms, as well as current insurance and financial information, may be necessary to determine eligibility and needs. Residency and degree of impairment are considered in determining eligibility.

Typically, only one contact is necessary to determine a consumer's needs. Additional services such as psychological testing, psychiatric evaluation or further assessments may be required to determine diagnosis and course of treatment.

Once a consumer is determined to be eligible for services, an individual plan of services is developed using a person centered planning process tailored to the individual's needs. At that time, consumers will be offered a choice of providers who are under contract with the CMHSPs. Services must be provided within 14 days of the assessment.

Eligibility Determination for Persons with a Developmental Disability[4]*:*

For individuals older than five years, a developmental disability is a severe, chronic condition that meets all of the following requirements:

A) is attributed to a mental or physical impairment or a combination of physical and mental impairments

B) is manifested before the individual is 22 years old

C) is likely to continue indefinitely

D) results in substantial functional limitation in three or more of the following areas of major life activities:

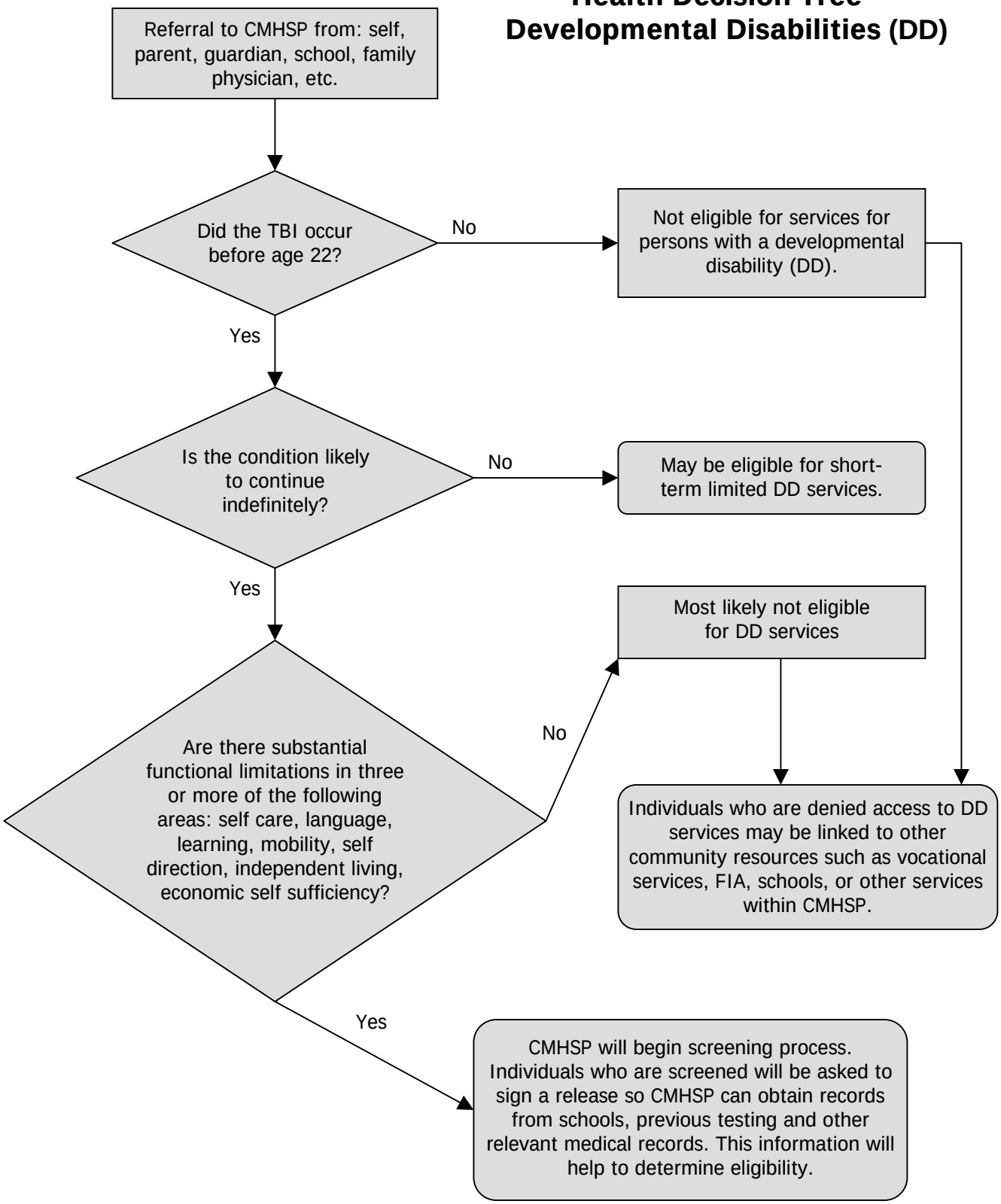
- self care
- receptive and expressive language
- learning
- mobility
- self direction
- capacity for independent living
- economic self sufficiency

E) reflects the individual's need for a combination and sequence of special, interdisciplinary or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.

For minors from birth to age five, a developmental disability is a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability as defined in item (A) if services are not provided.

[4] Persons with TBI may be classified as having a developmental disability.

Figure 1: Community Mental Health Decision Tree - Developmental Disabilities (DD)



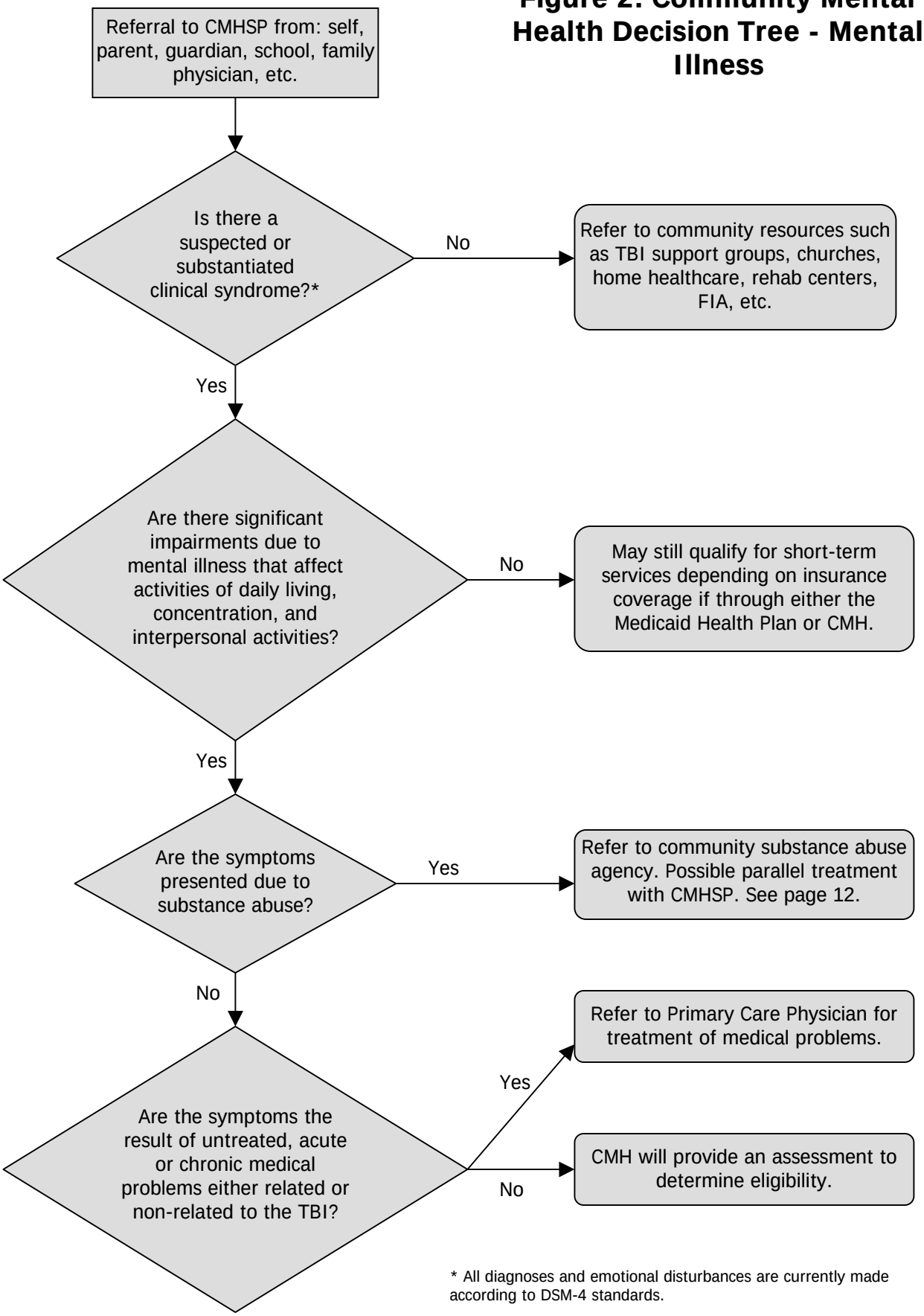
Eligibility Determination for Mental Illness:

A variety of methods may be employed to make determinations regarding the presence of mental illness and any medically necessary services. The determination of medically necessary services must be based on a person-centered planning process. Co-occurring substance use disorders or underlying medical conditions, such as TBI, should be evaluated and treated.

How mental illness affects other areas of a consumer's life (e.g., activities of daily living, concentration, interpersonal activities) is also considered in making the assessment of need for services.

When determining the presence and severity of mental illness, the presence of additional physical illness/medical problems or substance abuse problems needs to be considered for accurate diagnosis and effective treatment.

Figure 2: Community Mental Health Decision Tree - Mental Illness



* All diagnoses and emotional disturbances are currently made according to DSM-4 standards.

Substance Abuse (SA) - Central Diagnostic and Referral Agencies (CDR) / Access, Assessment and Referral Agencies (AAR)

Table 2: Overview of Substance Abuse Services

Substance Abuse Services	Direct Services Provided	Public Funding for Services[1]	Information & Referral Provided	Eligibility	Contact
Outpatient Services ▸Individual Therapy ▸Group Therapy ▸Family Therapy	Yes	Yes	Yes	Diagnosed substance abuse/addiction	Substance Abuse Coordinating Agency or Local CMHSP
Intensive Outpatient Services	Yes	Yes	Yes	Diagnosed substance abuse/addiction	Substance Abuse Coordinating Agency or Local CMHSP
Residential Services ▸Detoxification Services ▸Short-Term Residential Services ▸Long-Term Residential Services	Yes	Yes	Yes	Diagnosed substance abuse/addiction	Substance Abuse Coordinating Agency or Local CMHSP

[1] Funding for services may be limited due to budget constraints.

Description of Substance Abuse Services

The Michigan Department of Community Health contracts with Central Diagnostic and Referral Agencies (CDRs) or Access, Assessment and Referral Agencies (AARs) throughout the state to provide alcohol and drug abuse services. CDRs/AARs provide assessments and arrange for placement in appropriate services. A CDR/AAR must assess individuals who receive public funding before the individual may enter a treatment program. CDRs/AARs focus on individual needs through person centered planning to determine treatment. Continuum of care may include:

Outpatient Services

- Individual Therapy – Face-to-face counseling services are available for the consumer or the consumer's significant other.
- Family therapy – Face-to-face counseling with the consumer and his/her significant other and/or traditional or nontraditional family members is provided.
- Group Therapy – CDRs/AARs provide face-to-face counseling with three or more clients that can include didactic lectures, therapeutic discussions and other group related activities.

Intensive Outpatient Services Services are provided multiple days per week over a specified time period as determined by program design and the client's needs.

Residential Services

- Detoxification – Medically supervised care is provided in a sub-acute residential setting for the purpose of managing the effects of withdrawal from alcohol and/or other drugs.

A detoxification program must be staffed 24 hours per day, seven days per week, by a licensed physician or by the designated representative of a licensed physician. Services typically last three to five days.

- Short-Term Residential – Planned individual and/or group therapeutic and rehabilitative counseling and didactics are provided as an intense, organized, daily treatment regimen in a residential setting which includes an overnight stay. These programs have trained treatment staff supervised by a professional who is responsible for the quality of care. Such programs are typically 30 days or fewer.
- Long-Term Residential – This professionally supervised program includes planned individual and/or group therapeutic and rehabilitative counseling, didactics, peer therapy, and rehabilitative care. These services are provided in a residential setting and include an overnight stay. Such programs typically are longer than 30 days.

Contacting the Office

The Michigan Resource Center, (800-626-4636), will provide local CDR/AAR office information. When calling, an electronic menu will answer. “Other options” should be selected to talk to a person. Local information is also available in the phone book under “Substance Abuse” in the yellow pages. If it is not an emergency, an initial screening over the phone or in person will be done to determine eligibility and, if eligible, an appointment/treatment will be arranged. A referral will also be offered to eligible persons who walk into a location. Persons having substance related emergencies should visit the nearest emergency care unit of a local hospital.

A TTY should be requested for persons who have a hearing impairment, and translation will be available for those with limited English proficiency. TTY services must be made available to the consumer within 24 hours of contact.

Transportation services for meetings/appointments are specific to individual treatment agencies. The treatment agency may be able to coordinate transportation with local transportation providers.

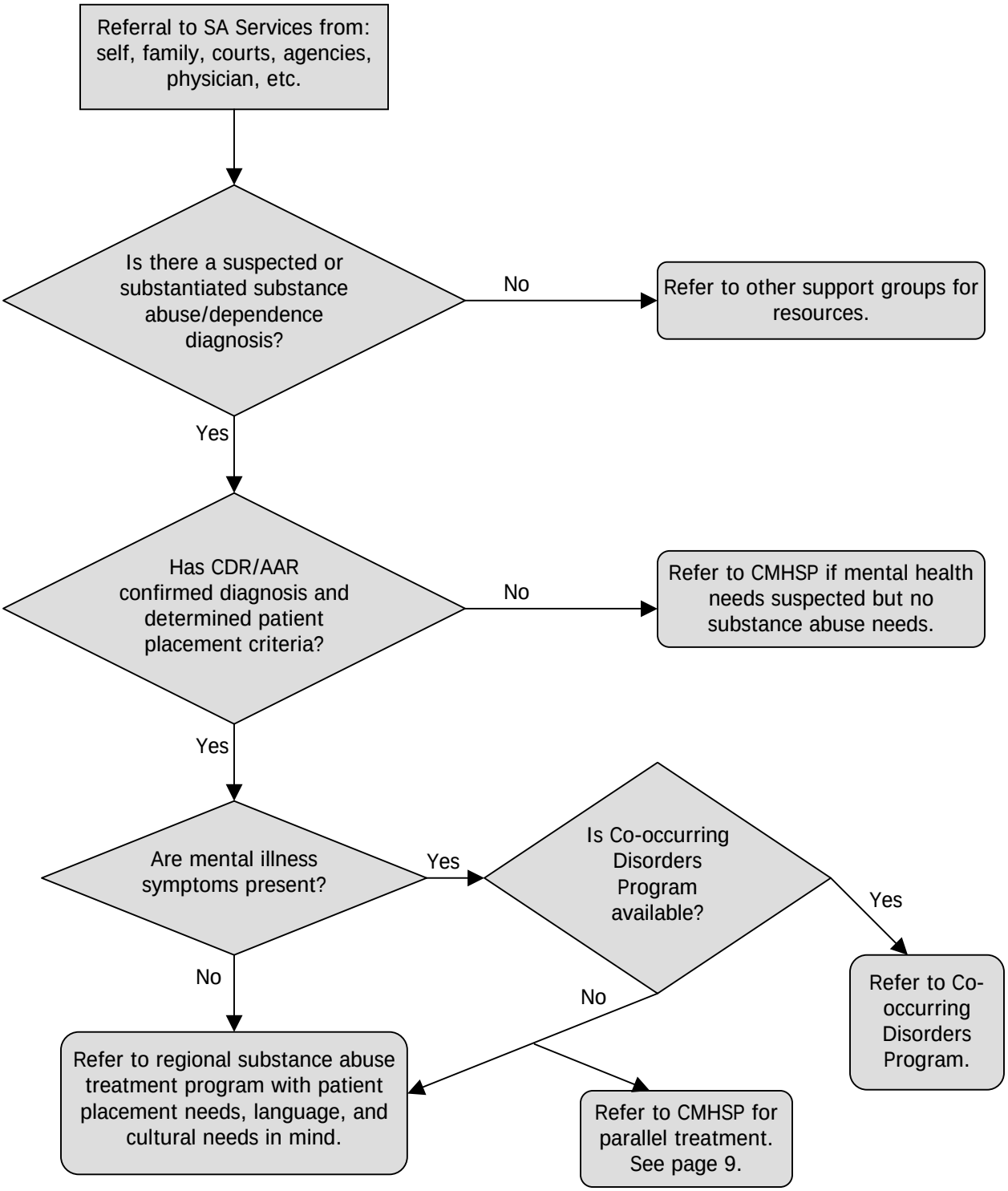
Determination of Needs and Eligibility

Individual needs are determined using standardized screening instruments and Patient Placement Criteria over the phone or in person. One or more contacts may be necessary before needs and eligibility are determined.

Eligibility requires a diagnosed substance abuse or addiction disorder and a need for publicly funded services. The consumer should be prepared to present documentation and information of financial status, current insurance, history of prior treatment and current substance use as requested to determine eligibility and needs.

Eligibility is typically determined during the first phone call or interview. Service provision is based on availability and acuity of needs. If the consumer is in crisis while waiting for services, he/she should call the treating agency to receive proper care or go to the nearest emergency care unit of a local hospital.

FIGURE 3: Substance Abuse (SA)/Dependence Decision Tree



How to Appeal a CMHSP or SA Determination

If a consumer disagrees with the determination of eligibility for services, the consumer has the right to appeal the decision and should receive written instructions from the treating agency with their determination notification on how to proceed with the appeal. A consumer has the right to engage an advocate or lawyer at any time during the process.

SECTION III.

FAMILY INDEPENDENCE AGENCY

Family Independence Agency (FIA)

Table 3: Overview of FIA Services

Family Independence Agency Services	Direct Services Provided	Public Funding for Services[1]	Information & Referral Provided	Eligibility	Contact
Adult Services					
▸Independent Living Services	Yes	No	Yes	None	Local FIA Office-Adult Services Unit
▸Home Help Services	Yes	Yes	Yes	Must be Medicaid eligible with a functional limitation-no age requirement	Local FIA Office-Adult Services Unit
▸Adult Community Placement	Yes	Yes	Yes	Must be Medicaid eligible	Local FIA Office-Adult Services Unit
▸Adult Protective Services	Yes	Yes	Yes	None	Local FIA Office-Adult Services Unit
▸Medical Equipment & Assistive Technology-Physical Disabilities Services	Yes	Yes	Yes	Must be Medicaid eligible, have a documented medical need and no other coverage	Local FIA Office-Adult Services Unit
Eligibility Determination					
▸Medicaid (MA) (Includes MI Child & Healthy Kids)	No	Yes	Yes	Low income/asset[2]	Local FIA Office-Medicaid Eligibility
▸State Medical Program	Yes	No	Yes	Must not be on Medicaid, no medical insurance and < $3000 in assets	Local FIA Office-Medicaid Eligibility
▸State Disability Assistance	Yes	Yes	Yes	Check with local FIA Office	Local FIA Office-Medicaid Eligibility
▸Family Independence Program (FIP)	Yes	Yes	Yes	Income, asset and family composition	Local FIA Office-FIP Staff
▸Food Assistance/Bridge Card[3]	No	Yes	Yes	Income and asset criteria	Local FIA Office-FIP & ES Staff

[1] Funding for services may be limited due to budget constraints.
[2]See Appendix 1: Medicaid Overview for listing of all Medicaid (MA) categories and unique, non-financial eligibility factors for each category.
[3]For assistance, call the local FIA Office for the toll free Bridge Card Hotline number.

Description of FIA Services

Adult Services

- Independent Living Services - FIA provides services to enhance independence and self-sufficiency.
- Home Help Services - This is an in home program to assist with activities of daily living to enable a person to remain in an independent living situation.
- Adult Community Placement Services - This program assists persons with making informed decisions about out-of-home living arrangements (adult foster care & home for the aged) when independent living is not possible. A Personal Care/Supplemental

payment may be available to cover some of the costs of those living arrangements if the customer is on Medicaid.

- Adult Protective Services - FIA staff investigate complaints of abuse, neglect and exploitation of vulnerable adults and provide linkage to needed community services.
- Medical Equipment and Assistive Technology - FIA provides information about sources of medical equipment and, in some cases, can provide payment for equipment and/or services that are not covered by Medicaid through Physical Disability Services.

Eligibility Determination Services

FIA offices determine eligibility for the federal Medicaid insurance programs. For a listing of all Medicaid categories and unique non-financial eligibility factors for each category, see the "Medicaid Overview" (Appendix 1).

- Medicaid - See the "Medicaid Overview" (Appendix 1). Persons qualifying for Supplemental Security Income (SSI) are automatically eligible for Medicaid. Persons who might qualify for SSI should be referred to Social Security Administration.
- State Medical Program - FIA determines eligibility for the State Medical Program, which may cover basic outpatient medical care to lower income individuals between the ages of 21 and 65.
- State Disability Assistance (SDA) Program - FIA determines eligibility for the SDA Program through which a customer can receive a monthly grant. The customer must be determined to have a disability that is expected to last at least 90 days but not more than one year.
- Family Independence Program (FIP) - FIP provides financial assistance to families with children. The goal of FIP is to maintain and strengthen family life for children and the parents or other caretaker(s) with whom they are living, and to help the family attain or retain capability for maximum self-support and personal independence.
- Food Assistance Program (FAP)/Bridge Card - The purpose of this program is to raise the food purchasing power of low-income persons. Benefits are issued using electronic technology and a debit card known as the Bridge Card.

Contacting the Office

Customers should call their local FIA office listed in the phonebook under "State Government" or "County Government" and ask for the Adult Services Unit, or visit the website: www.michigan.gov/fia. An Adult Service worker will be able to refer callers to the appropriate person. An FIA worker may be assigned to work with the customer at that time. Any applicant has the right to bring with them an advocate to assist in the application process.

TTY is available in all FIA offices to address any speech impairments. FIA staff persons can make home visits and may arrange for transportation to medically required appointments for persons who are medically eligible.

Determination of Needs and Eligibility

A caseworker is provided to assist with determining eligibility for Medicaid, State Medical Program and other financial programs; a case manager is provided to assist with eligibility determination for adult and child Services Programs. Customers should call a local FIA office and ask whom to speak to about eligibility determination, as processes can vary from one FIA office to another.

Eligibility criteria for each FIA service are different. Eligibility is based on such factors as income, assets, health and/or living situation. Because staff workers in local FIA offices are specialized, and cover financial and Medicaid (and State Medical) programs as well as other services (adult, children[5]), it is best if the customer asks for the program they are interested in by name. This is especially important in the larger FIA county offices that have multiple locations, each of which may not cover all available services in that county. Customers should call the main phone number for their county FIA to find out which office offers the program in which they are interested. Documentation needed to determine eligibility and needs may vary for each program that FIA offers.

A formal assessment will be conducted by an FIA staff person to determine the needs of each customer. Eligibility for most FIA programs that could be of benefit to persons with TBI must be determined in 30-60 days.

[5] Includes MI Child and Healthy Kids

Figure 4: FIA Decision Tree Support for Financial/Healthcare Needs

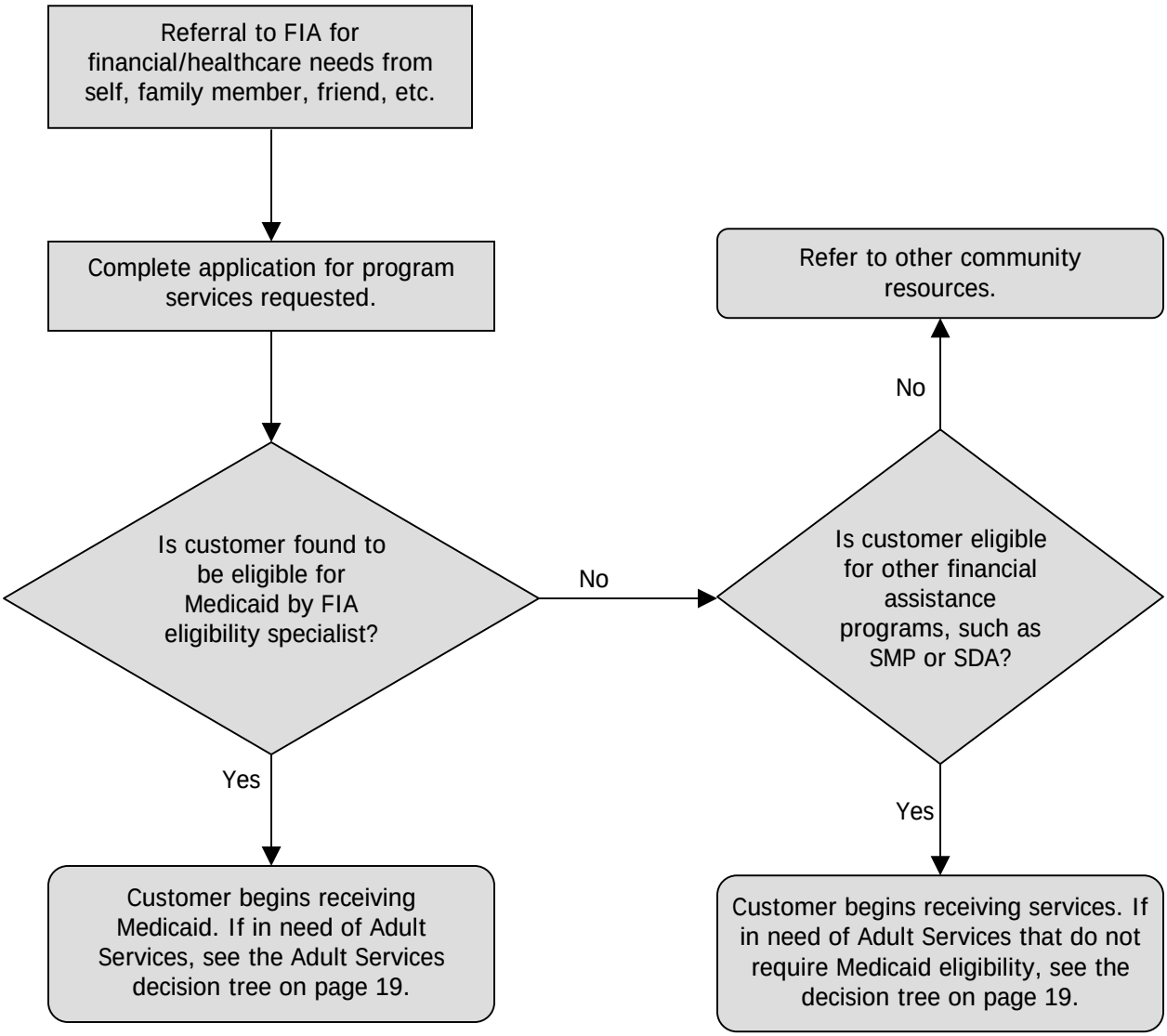
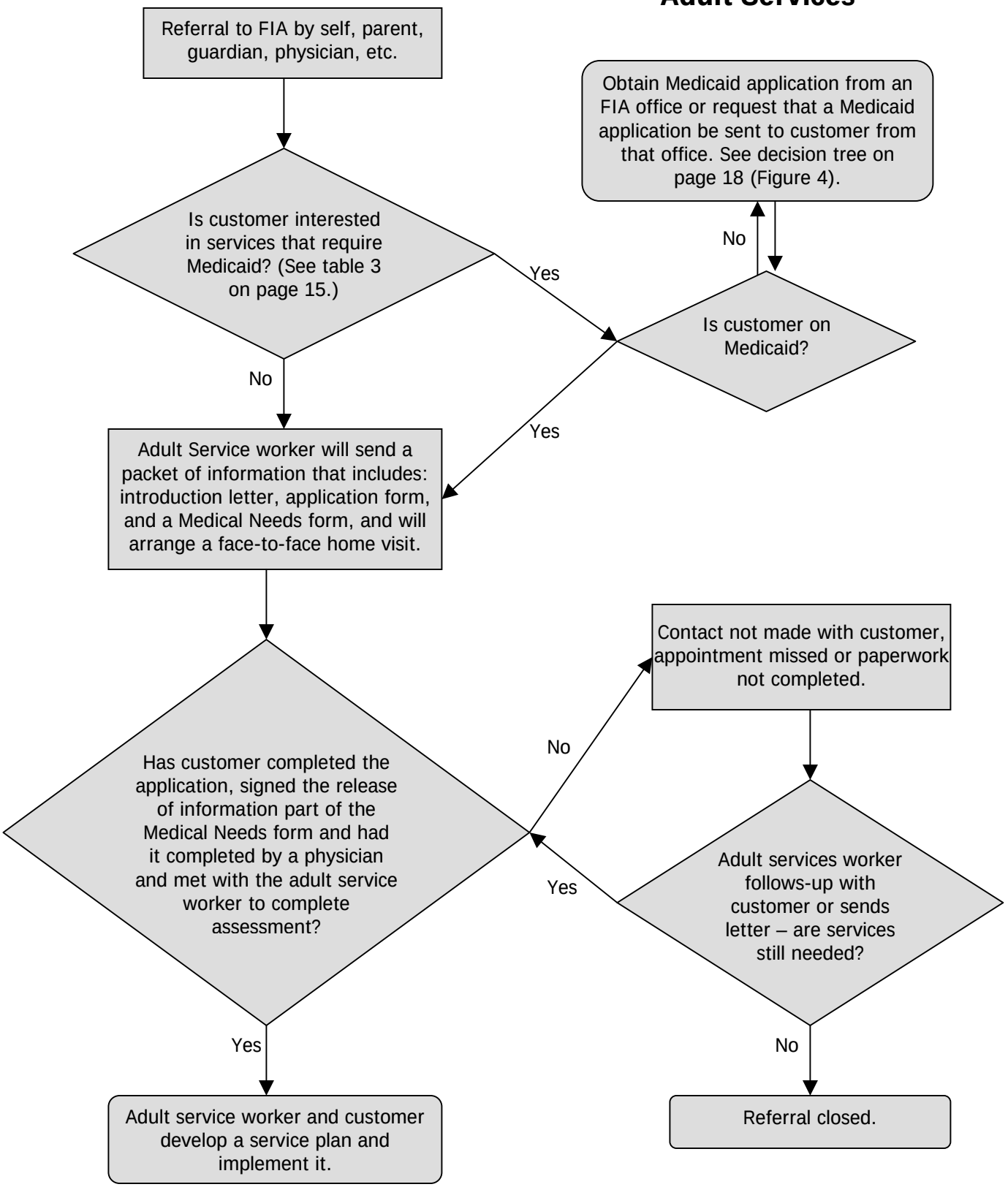


Figure 5: FIA Decision Tree Adult Services



How to Appeal an FIA Determination

Customers may reapply for services anytime they feel their situation has changed to make them eligible. An advocate can be helpful from the point of application to clarify an applicant's wishes and help to obtain necessary eligibility documentation.

Every FIA customer has the right to request a hearing if they feel that services and/or funding were denied or reduced inappropriately. Information on how to request a hearing is part of the official notification letter of denial or reduction.

Hearings involving Medicaid issues are handled by the Administrative Tribunal of the Department of Community Health (DCH). Hearings not involving Medicaid are handled by Administrative Hearings staff in the FIA Bureau of Legal Affairs. There may be multiple levels to the appeals process, including the opportunity for a review of the hearing decision.

SECTION IV.

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH - LONG TERM CARE PROGRAMS

Michigan Department of Community Health (MDCH) – Long Term Care Programs (LTC)

Although a funding source, MDCH is not a direct provider of services. LTC staff can assist with initial information and referral in many cases, but persons seeking specific LTC services should be referred to the contacts listed in the table below.

Table 4: Overview of LTC Services

Long Term Care Services	Direct Services Provided	Public Funding for Services[1]	Information & Referral Provided	Eligibility	Contact
Assessment & Rehabilitation of TBI	No	Yes	Yes	Must be Medicaid eligible and meet medical criteria	MDCH Brain Injury Rehabilitation Program (517) 241-4293
Home and Community Based Services					
▸Home Health	No	Yes	Yes	Medical criteria/ Physicians order	Primary Care Physician or Home Health Agency
▸Private Duty Nursing	No	Yes	Yes	Medical criteria	Primary Care Physician or Private Duty Nursing Agency
▸Home Help	No	Yes	Yes	Functional limitation	FIA Office - Adult Services Unit
▸Physical Disability Services (PDS)	No	Yes	Yes	Medical need	FIA Office - Adult Services Unit
▸MI Choice Waiver	No	Yes	Yes	Over 18 & meet nursing facility level of care	Waiver Agent or www.1866michltc.net
Assistive Living Services					
▸Unlicensed Facilities	No	Yes	Info – yes Referral - No	N/A	Individual facility
▸Licensed Facilities	No	Yes	Info – yes Referral - No	N/A	www.cis.state.mi.us/brs
–Adult Foster Care	No	Yes	Yes	Over 18	FIA Office - Adult Services Unit
–Homes for the Aged	No	Yes	Yes	Over 60	FIA Office - Adult Services Unit
Nursing Facilities	No	Yes	Info – yes Referral - No	Must need nursing facility level of care	Individual facility or www.cis.state.mi.us/bhs
Hospice	No	Yes	Yes	Must be near the end of life	Local Hospice agency or www.mihospice.org
Respite Services	No	Yes	Yes	Over 18 with an unpaid caregiver in the home	Area Agency on Aging or www.1866michltc.net

[1] Funding for services may be limited due to budget constraints.

Assessment and Rehabilitation of TBI

Description of Assessment and Rehabilitation Services

Medicaid covers post-acute, comprehensive, intensive, goal-directed rehabilitation services for persons with a brain injury. The specialized program of integrated services is not otherwise available outside of an institutional rehabilitation setting. When the beneficiary presents a documented need for continued specialized rehabilitation services and the complexity of the case indicates the need for a comprehensive, multidisciplinary team approach then services may be authorized in a Medicaid approved residential or outpatient rehabilitation program. This program is usually accessed by a hospital or rehabilitation center on behalf of the beneficiary. Program capacity is dependent upon provider availability.

This program is available to Medicaid beneficiaries 18 years or older. Beneficiaries must meet financial and medical eligibility criteria.

Contacting the Office

When calling the MDCH Brain Injury Rehabilitation Program number listed in the table on page 21, ask to speak with someone about the TBI rehabilitation program.

A trained professional will travel to the consumer's residence if a personal meeting is required.

Determination of Needs and Eligibility

Needs are assessed by a hospital or a rehabilitation center. Medical records and other personal history documents may be requested to determine needs and eligibility.

Eligibility can be determined quickly (2-3 wks) with medical documentation. There is no waiting list, but availability of services may depend on the rehabilitation facility.

Financial Eligibility Requirements:

The beneficiary must meet financial eligibility as specified by the Family Independence Agency (FIA). The beneficiaries also must have exhausted all other available resources. If the beneficiary is receiving Supplemental Security Income (SSI), the beneficiary is responsible for room and board payments from the SSI income.

Medical Eligibility Requirements:

Rehabilitation must be medically necessary and ordered by a Michigan licensed physician. The neurological damage must have occurred within the previous 15 months; or a significant, measurable change must have occurred within the past 3 months. (An example of significant change is a change from one Los Amigo Ranchos Scale level to a higher or lower level.) A complete neuropsychological evaluation must be completed within three months of the request for services.

The individual must be medically stable and demonstrate the ability to follow verbal, non-verbal or written directions. The individual must be awake and alert for at least 10 hours a day; bowel and bladder trained, able to perform personal hygiene and grooming with standby cueing assistance and be mobile with or without assistive devices.

For **residential placement**, the individual must be able to participate actively in a minimum of three hours of meaningful, intensive, professional therapy a day or 21 hours per week.

For **outpatient placement**, the individual must be able to actively participate in a minimum of 10 hours of meaningful, intensive, professional therapy per week.

A trained professional is available for case management beginning at the time of application.

Home and Community Based Services & Assisted Living Services

Description of Home and Community Based Services

Home Health – Skilled nursing care is provided by a registered nurse or home health aid.

Private Duty Nursing – Skilled nursing care is provided for four continuous hours per day.

Home Help – Home Help provides unskilled hands-on personal care.

Physical Disability Services (PDS) – PDS provides assistance purchasing durable medical equipment and home modifications not otherwise covered by Medicaid.

MI Choice Waiver – Financial support is provided for services and personal care that allow an individual to remain in their home.

Description of Assisted Living Services

Unlicensed – Consumers should consult a facility to find out which services are provided.

Licensed

- Adult Foster Care – A living situation where room, board, personal care and supervision for persons over 18 years of age are provided.
- Homes for the Aged – A living situation where room, board, personal care and supervision for persons over 60 years of age are provided.

Contacting the Service Provider

A person seeking information about one of the Home and Community Based Services or Assisted Living Services should follow the directions in the table on page 21 and ask for information regarding the program in question. A trained professional will travel to the consumer's residence if a personal meeting is required.

Determination of Needs and Eligibility

A formal assessment is conducted by a trained professional to determine a person's needs. Each program determines eligibility differently.

Home and Community Based Services

- Home Health – The consumer must be Medicaid or Medicare eligible and meet medical criteria or have a physicians order to receive Home Health services.
- Private Duty Nursing – Consumers must be Medicaid eligible and meet medical criteria.
- Home Help Services – Consumers must be Medicaid eligible and have a functional limitation.
- Physical Disability Services (PDS) – Consumers must be Medicaid eligible and have a medical need.
- MI Choice Waiver – Consumers must be Medicaid eligible, be over 18 and meet nursing facility level of care criteria.

Assisted Living Services

- Licensed and Unlicensed facilities - must be SSI/Medicaid eligible if Medicaid is paying for services. Admission criteria will vary between each adult foster care home.

The following documentation and information may be asked for to determine eligibility: medical condition, demographics, functional ability, medications, support system and other services received. For MI Choice Waiver, income and asset information for Medicaid eligibility will also be required.

Eligibility determination may take up to 45 days for all Home and Community Based Services and Assisted Living Services. Interim services, pending Medicaid eligibility, are not provided for any of the home and community based programs, except for MI Choice Waiver. Services for MI Choice Waiver will be provided if the applicant is Medicaid eligible, but will be terminated if the applicant is not determined to be financially eligible for MI Choice Waiver.

A case manager is provided for all home and community based programs. Some programs allow beneficiaries to hire family members or friends. Contact the program for more information.

Nursing Facilities

Description of Nursing Facility Services

Nursing facilities offer twenty-four hour skilled nursing care for post acute and long-term needs.

Contacting the Service Provider

When contacting a nursing facility, a consumer should ask to talk to someone from admissions for information regarding the facility, and to request a tour.

Nursing facilities do not generally provide transportation.

Determination of Needs and Eligibility

Eligibility is determined by medical need and a doctor's order. The following documentation and information may be asked for to determine eligibility: medical condition, demographics, functional ability, medications, support system and other services received. For MI Choice Waiver, income and asset information for Medicaid eligibility will also be required.

Interim services are provided while waiting for eligibility determination, but the consumer may be responsible to pay for their stay if Medicaid is not approved. A case manager is not provided.

Hospice

Description of Hospice Services

Hospice services include skilled care, personal care, pain management, counseling and family support for people at the end of life and their families.

Contacting the Service Provider

When calling a hospice agency, ask for an intake person. Hospice workers will travel to the consumer's residence.

Determination of Needs and Eligibility

A statement from a doctor showing that the person is expected to die within 6 months is necessary to receive hospice services. A formal assessment is done to determine a person's needs.

Eligibility determination and provision of hospice services typically takes place very quickly, and interim services are provided while waiting for eligibility determination. A caseworker will be assigned to the consumer at the beginning of the application process.

Respite

Description of Respite Services

Respite services are provided in an individual's/family's home or outside the home to temporarily relieve the unpaid primary caregiver. The goal is to provide short-term relief from the stress of caregiving.

Contacting the Office

For information on respite services, contact the local Area Agency on Aging or visit the website www.1866michltc.net. Respite workers will travel to the consumer's residence.

Determination of Needs and Eligibility

The beneficiary must be over 18 with an unpaid caregiver in the home.

How to Appeal an LTC Determination

If a consumer does not agree with their eligibility determination, he/she can appeal the decision. Because LTC is not a direct service provider, appeals should be filed with the agency to which application was made or to the program from which services are received by following the appeals procedure for that agency. Having an advocate is recommended throughout the application process. A person may reapply for services when his/her situation has changed such that the eligibility criteria will be met.

For Hospice: If services are denied, a consumer, or family members on behalf of the consumer, may reapply as soon as they receive the necessary statement from a doctor. If a consumer does not agree with a determination, the consumer will need to follow the appeals process for Medicare and Medicaid.

SECTION V.

MICHIGAN DEPARTMENT OF EDUCATION – OFFICE OF SPECIAL EDUCATION AND EARLY INTERVENTION SERVICES

Michigan Department of Education – Office of Special Education and Early Intervention Services

Table 5: Overview of Public Education Services

Public Education Services	Direct Services Provided	Public Funding for Services	Information & Referral Provided	Eligibility	Contact
Special Education for Infants and Toddlers	Yes	Yes	Yes	Age: birth - 2	Local ISD or local public school administrator for special education services
Special Education for Children aged 3-26	Yes	Yes	Yes	Age: 3 - 25	Local ISD or local public school administrator for special education services
Transition Planning	Yes	Yes	Yes	Age: 14 - 25	Local ISD or local public school administrator for special education services

Description of Public Education Services

Special Education for Infants and Toddlers The Individualized Family Service Plan (IFSP) is for infants and toddlers from birth through age two who are experiencing developmental delays and/or who have been diagnosed with a physical or mental condition that may result in developmental delay. The IFSP identifies the supports each infant/toddler and the family is to receive. Some services that might be included are speech and language services, school occupational or physical therapy, orientation and mobility training, an interpreter, assistive technology and consultant services. School professionals may also address hearing, vision, sensory, and behavioral concerns.

Progress of the IFSP is evaluated every six months. Evaluations involve a number of professional school staff working with the child and parents in conjunction with physicians, and community agencies.

Special Education for Students Aged 3-25 The Individualized Education Program (IEP) is for students with disabilities from age 3 through 25 who have not earned a high school diploma or the equivalent and have been found to be eligible for and in need of a special education program or service. Some of the services might include special education classrooms, speech and language services, school occupational or physical therapy, orientation and mobility training, an interpreter, assistive technology and consultant services. School professionals may also address hearing, vision, sensory, and behavioral concerns.

Progress of the IEP is evaluated at least every year. Evaluations involve a number of professional school staff working with the child and parents in conjunction with physicians, and community agencies.

Transition Planning The Individuals with Disabilities Education Act (IDEA) requires transition planning for special education eligible students beginning at age 14. A

Transition Plan arranges an appropriate course of study as students move from adolescence to adulthood. Students can learn academic, vocational and life skills necessary for independent or semi-independent functioning.

Determination of Needs and Eligibility

Students aged birth through 25, who have not graduated from high school may be eligible for special education services. [6] If a student is suspected of having a disability he/she will be assessed after the parents sign the initial consent for the evaluation. The evaluation is conducted by a Multidisciplinary Evaluation Team (MET). Members of the team must include at least 2 persons, one of whom must be a special education teacher or other specialist with knowledge in the area of the child's disability.

The appropriate MET members will complete a diagnostic evaluation and a written report, and will recommend eligibility. The MET uses aptitude and achievement tests, teacher and parent input, educational data, physical condition, social or cultural background, adaptive behavior and other pertinent information that helps to identify the current level of educational performance. Relevant, current documentation or evaluations may be requested to determine needs and eligibility.

After completing the evaluation, the school district must convene an Individualized Education Program Team (IEPT) meeting and must invite the parents to participate. The IEPT determines whether the student is eligible for special education and is in need of special education. If so, the IEPT identifies the specific education the student is to receive, the type and amount of related services, instructional outcomes, goals and objectives, etc. All of this is documented in the IEP. Parents must provide consent the first time an IEP is implemented. For future IEPs, parents must be informed of what the district is proposing for the IEP although, in most circumstances, further consent is not needed.

The school district must determine eligibility within 30 schools days after the parent/guardian signs the initial consent. If the student is found to be eligible and has a need for services, a special education service provider will be assigned to the student as the service coordinator.

When a student with a disability reaches the age of majority (age 18 in Michigan if a legal guardian has not been appointed by the court), the local school district will provide notice that the parent's rights are transferred to the child.

[6] If a student is 25 at any time during the school year, they may be eligible for special education services.

Figure 6: Special Education Decision Tree – Infants & Toddlers

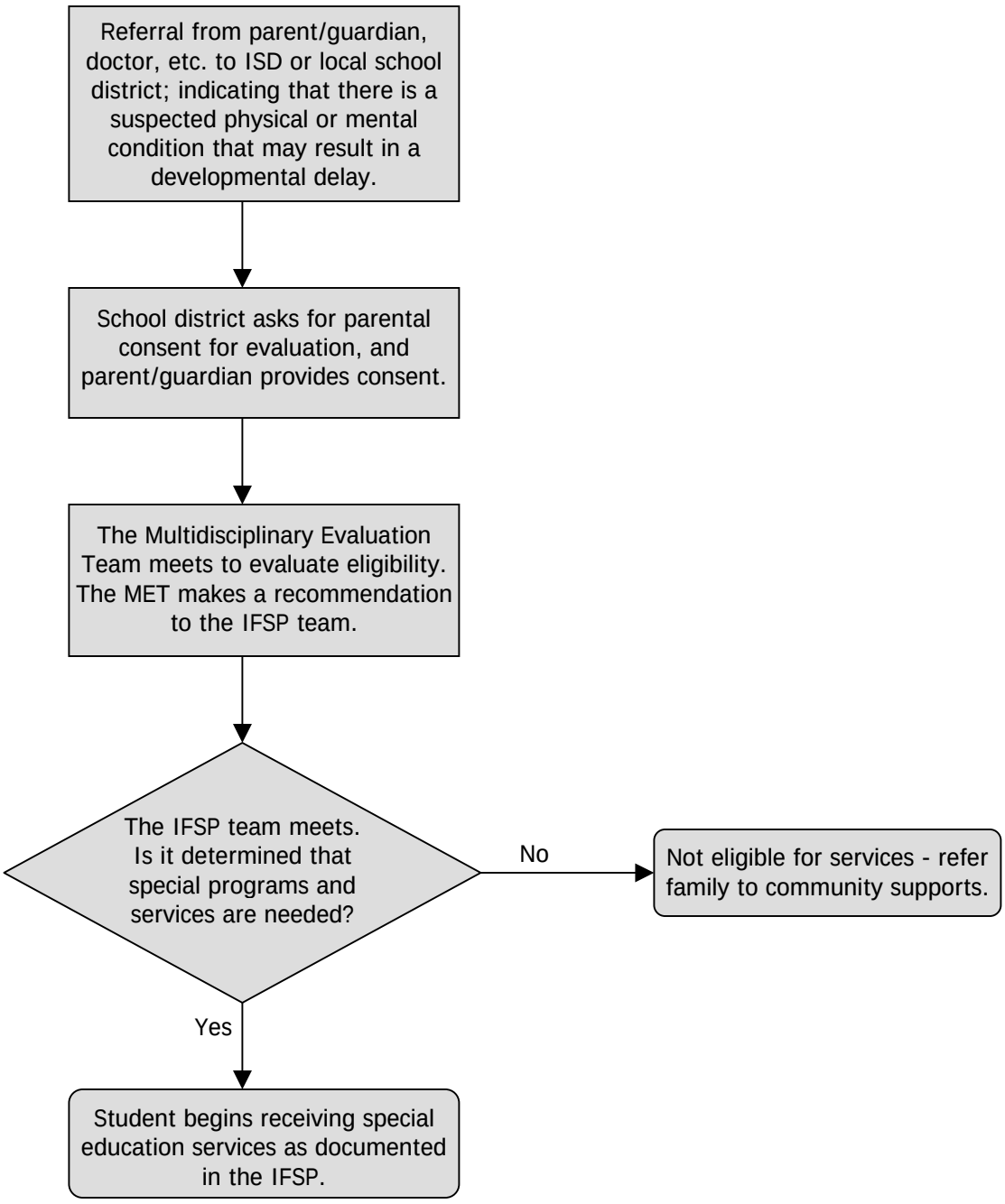
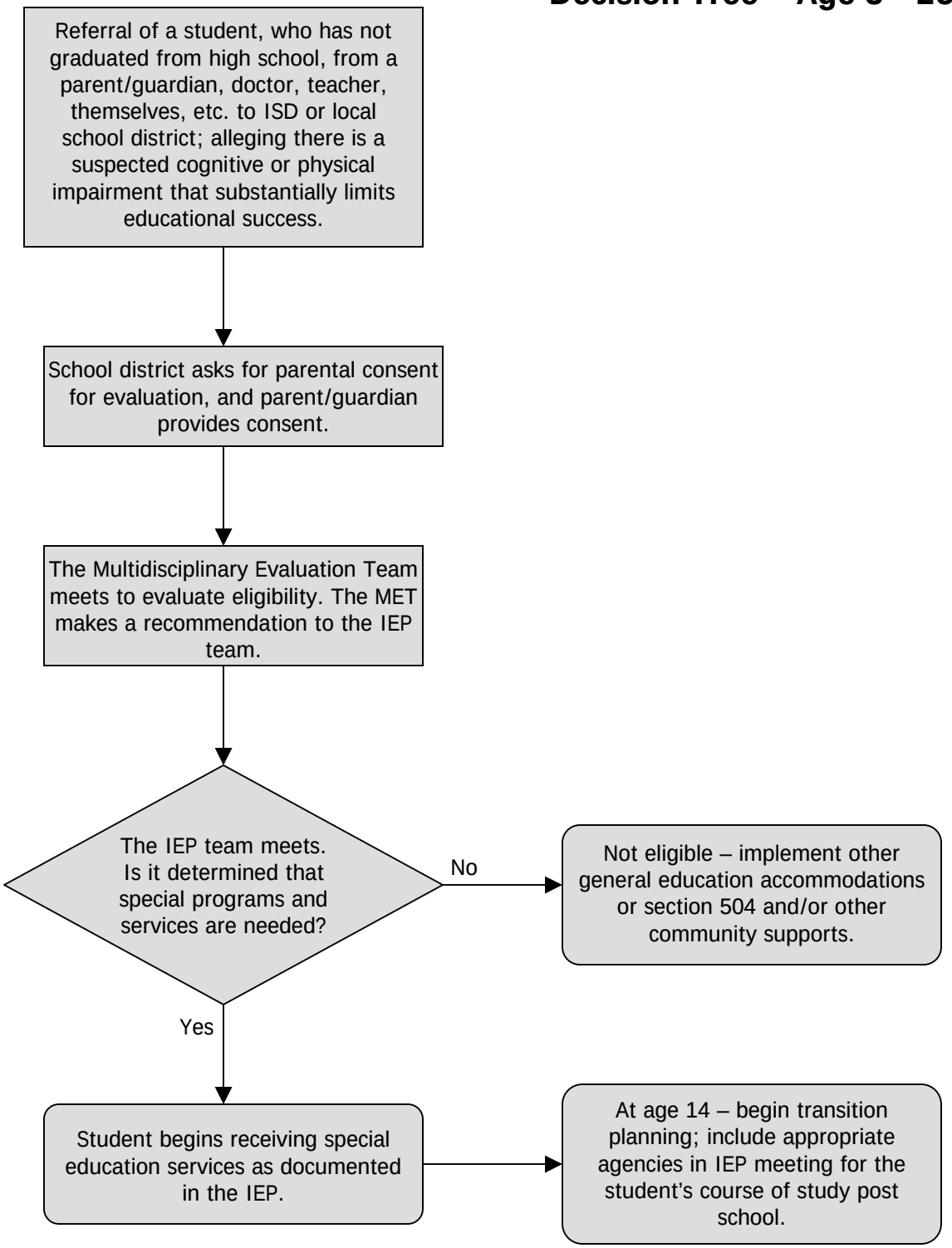


Figure 7: Special Education Decision Tree – Age 3 - 25



How to Appeal a Public Education Determination

If parents disagree with a determination, they can ask for an Independent Educational Evaluation through the local school district or through the Intermediate School District at public expense. Parents, at no expense, may ask for mediation or invoke a due process hearing.

Other rights are spelled out in the Procedural Safeguards which is given to the parents at the initial referral for evaluation, annual notification of an individualized education program (IEP) meeting, a re-evaluation (usually held every three years), registration of a due process complaint, or before the date on which the decision to take disciplinary action involving a change in placement might occur.

An educational advocate can be utilized throughout the process at no cost to the parent.

Contacting the Office

For information about special education, or to arrange for an evaluation for their child, parents should contact the local Intermediate School District (ISD) office, or the local public school district administrative office, and ask to speak with the administrator responsible for special education services.

Parents have the right to have an interpreter/translator present if their primary language is not English or if the student is deaf/hearing impaired or visually impaired, unless it is clearly not feasible to do so.

Transportation is a special education service decided by the IEP Team. Appropriate special education school staff and others (from other agencies) will service infants and toddlers from birth to age 2, in the home.

Appendix I. – Medicaid Overview

MEDICAID OVERVIEW

AGENCY POLICY

MA Only

The goal of the Medicaid program is to ensure that essential health care services are made available to those who otherwise could not afford them. Medicaid is also known as Medical Assistance (MA).

SSI-RELATED AND FIP-RELATED

The Medicaid program is comprised of several sub-programs (i.e., categories). One category is for Family Independence Program (FIP) recipients. Another category is for Supplemental Security Income (SSI) recipients. There are several other categories for persons not receiving FIP or SSI. However, the eligibility factors for their categories are based on (related to) the eligibility factors in either the FIP or SSI program. Therefore, these categories are referred to as either FIP-related or SSI-related.

To receive MA under an SSI-related category, the person must be aged (65 or older), blind, disabled, entitled to Medicare or formerly blind or disabled.

Families with dependent children, caretaker relatives of dependent children, persons under age 21 and pregnant, or recently pregnant, women receive MA under FIP-related categories.

GROUP 1 AND GROUP 2

In general, the terms Group 1 and Group 2 relate to financial eligibility factors. For Group 1, net income (countable income minus allowable income deductions) must be at or below a certain income limit for eligibility to exist. The income limit, which varies by category, is for non-medical needs such as food and shelter. Medical expenses are not used when determining eligibility for FIP-related and SSI-related Group 1 categories.

For Group 2, eligibility is possible even when net income exceeds the income limit. This is because incurred medical expenses are used when determining eligibility for FIP-related and SSI-related Group 2 categories.

MA Category	Unique Non-financial Eligibility Factor	Financial Eligibility Group	Automatic MA Eligibility
FIP-related categories:			
Family Independence Program (FIP)	Family with dependent children	1	Yes
Low-income Family MA	Family with dependent children	1	No
Transitional MA	Family with children	1	Yes
Special N/Support	Family with dependent children	1	Yes*
Title IV-E Recipients	Under age 21	1	Yes
Department Wards	Under age 21	1	Yes
Healthy Kids for Pregnant Women	Pregnant or recently pregnant	1	No
Group 2 Pregnant Women	Pregnant or recently pregnant	2	No
Healthy Kids Under Age 1	Under age 1	1	No
Other Healthy Kids	Under age 19	1	No
Group 2 Persons under Age 21	Under age 21	2	No
Group 2 Caretaker Relatives	Caretaker of dependent child	2	No
Newborns	Newborn	1 or 2	Yes**
SSI-related categories:			
Supplemental Security Income (SSI)	Aged, blind or disabled	1	Yes
Appealing SSI Termination	Appealing SSI termination	1	No
Special Disabled Children	Former SSI recipient child	1	No
503 Individuals	Aged, blind or disabled	1	No
COBRA Widow(er)s	Aged, blind or disabled	1	No
Early Widow(er)s	Blind or disabled	1	No
Disabled Adult Children (DAC)	Aged, blind or disabled	1	No
AD-Care	Aged or disabled	1	No
Extended-Care	Aged, blind or disabled	1	No
Medicare Savings Programs	Medicare Part A	-	No
Group 2 Aged, Blind and Disabled	Aged, blind or disabled	2	No
Qualified Disabled Working Individuals (QDWI)	Type of Medicare	-	No
Home Care Children	Disabled	1	No
Children's Waiver	Disabled	1	No

* Once established, MA eligibility continues automatically as long as the family remains Michigan residents

** As long as the newborn lives with his mother who is an MA recipient or meets certain MA eligibility factors

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